TENNESSEE GENERAL ASSEMBLY
FISCAL REVIEW COMMITTEE

FISCAL NOTE

HB 1162 - SB 1061

April 1, 2011

SUMMARY OF BILL: Prohibits a health insurance entity from unreasonably denying coverage for a medical procedure or test that the entity decides is not medically necessary. The denial will be presumed unreasonable if an insured individual seeks medical care at his or her own expense after the denial and the procedure or test proves to be medically necessary based on the results. If a health insurance entity is found to have unreasonably denied coverage, the entity shall reimburse the insured for all expenses incurred associated with the procedure or test at 100 percent of the incurred expenses, any out-of-pocket expenses incurred, and any damages sustained by the insured due to the delay in obtaining the medical procedure or test.

ESTIMATED FISCAL IMPACT:

Increase State Expenditures – Exceeds $100,000

Increase Local Expenditures – Exceeds $100,000*

Potential Impact on Health Insurance Premiums (required by Tenn. Code Ann. § 3-2-111): Such legislation is estimated to result in an increase in the cost of health insurance premiums by an amount that exceeds $100,000 for the payments of procedures that would not covered and the amount of any damages that an enrollee may be awarded.

Assumptions:

- The Department of Commerce and Insurance will enforce the provisions of the bill through complaint investigations received from providers and enrollees. Any cost can be accommodated within existing resources without an increased appropriation or reduced reversion.
- According to the Bureau of TennCare, the bill will not impact the current procedures for appeals of denial decisions. No impact to state or federal expenditures.
- According to the Department of Finance and Administration, the state sponsored public sector plans have accelerated appeals processes to minimize occurrences where medical treatment is inappropriately delayed.
- A precise impact is difficult to determine due to a number of unknown factors, including, but not limited to, the number of denials that will be paid for by the insured and the cost of those procedures, the number of those procedures that will be determined medically necessary, and the amount of damages that will be awarded.

- It is reasonably estimated that the recurring increase in state expenditures will exceed $100,000 for the costs of the procedures that would not be covered under the current medically necessary determination procedures and the amount of any damages that will be awarded.
- It is assumed that local governments that provide health insurance coverage for employees, but do not opt into the state sponsored public sector plans, will incur a similar impact as the state resulting in an increase in local expenditures exceeding $100,000.
- Private health insurance impact: Private health insurance providers have procedures in place to determine the types of benefits and the amount for those benefits that will be covered in order to manage their costs as well as the out-of-pocket costs of the enrollees. Most providers also have some type of denial and appeals process for instances where procedures or treatments are not covered under an enrollee's plan. If an insurance provider is required to cover a procedure or treatment that is not covered under an enrollee's plan and also pay for damages to that individual, those additional costs will shift to all enrollees through increased premiums and other out-of-pocket expenses. It is estimated that any increase in premiums will exceed $100,000.

*Article II, Section 24 of the Tennessee Constitution provides that: *No law of general application shall impose increased expenditure requirements on cities or counties unless the General Assembly shall provide that the state share in the cost.*

CERTIFICATION:

The information contained herein is true and correct to the best of my knowledge.

James W. White, Executive Director

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